NEW HAMPSHIRE INSURANCE DEPARTMENT

MEDICAL PROFESSIONAL LIABILITY INSURANCE CLAIM REPORT

Date Report Prepared:

MAIL TO: NHID - P&C DIVISION
21 SOUTH FRUIT ST, SUITE 14
CONCORD NH 03301

SEE INSTRUCTIONS ON REVERSE **PLEASE TYPE OR PRINT**

1a NAME OF INSURER	1b ADDRESS OF INSURER	1c NAIC GROUP & COMPANY CODE

1d CONTACT PERSON RESPONSIBLE FOR THE REPORT

Name Title Tel. No. E-Mail

CLAIM FILE IDENTIFICATION

2a Claim Number	2b Date of Injury	2c Date Reported	2d Date Reopened	2e Original Claim Number

2f Place of Occurrence Code	2g Place of Occurrence Address	2h Total Number of Defendants in Claim

2i Companion Claim File Identification

1 **2** **3** **4**

INSURED

3a Name 3b License Number 3c Date of Birth

3d Address (Street, P.O. Box, City/Town, State, Zip Code)

3e Profession Code of Insured 3f Specialty Code of Insured 3g Practice Code of Insured

INSTITUTION (IF INJURY OCCURRED IN INSTITUTION)

4a Name:	4b Address:	4c Location of Injury Code:

INJURED PERSON

5a Name 5d Address	5b Date of Birth	5c Sex

6a Name of Person Instituting the Claim, if injured person is deceased or a minor

6b Address

7a Plaintiff Attorney's Name	7b Plaintiff Attorney's Firm	7c Address

CLAIM INFORMATION AND SETTLEMENT DATA

8a Nature and Substance of Claim	8b Severity of Injury Code

8c Act or Omission Codes (Enter three Digit Code in Appropriate Category)

Diagnosis ☐ Anesthesia ☐ Surgery ☐ Medication ☐ Intravenous & Blood Products ☐

Obstetrics ☐ Treatment ☐ Monitoring ☐ Biomedical Equipment/Product Medication ☐ Miscellaneous ☐

9a Reserve Amount for Indemnity	9b Reserve Amount for Expense

10 Date of Payment or Closure	11 Screening Panel Code	12 Settlement Code

13a Court Code	13b Name of Court	13c Docket Number	13d Date Suit Was Filed

14 Indemnity paid by you on behalf of this defendant	$	18 All other allocated loss adjustment expense paid by you	$
14a Economic damages	$	19 Injured person's incurred medical expense	$
14b Non-economic damages	$	20 Injured person's anticipated future medical expense	$
14c Punitive damages	$	21 Injured person's incurred wage loss	$
15 Other indemnity paid by or on behalf of this defendant	$	22 Injured person's anticipated future wage loss	$
16 Indemnity paid by all parties (for all defendants)	$	23 Injured person's other expenses	$
17 Loss adjustment expense paid to defense counsel	$		

MEDICAL PROFESSIONAL LIABILITY INSURANCE CLAIM REPORT **INSTRUCTIONS**

Submit an initial report when a claim/demand for payment of damages is received in writing from claimant, a lien letter was received or a lawsuit has been filed.
An incident is not to be reported until it becomes a claim. All claims closed without payment and claims with payment must be reported. Report all dollar amounts in whole $$$, all dates as MM/DD/YY.
Reports are to be submitted to the Insurance Department on a quarterly basis after the initial report until the claim is settled and closed.
To report an open claim, Items 1 through 9b must be completed. When a claim is closed, the total form must be completed. Attach an explanation for any items left blank.

1a. **Name of Insurer**: Enter name of company or self-insurer reporting this claim.
1b. **Address of Insurer**: Enter address of company or self-insurer reporting this claim
1c. **NAIC Group & Company Code** For insurance companies use NAIC group-company code; self-insurers contact Insurance Department for assigned number.
1d. **Contact Person Responsible for the Report.** Enter contact's name, title, tel. #, e-mail address.
2a. **Claim Number**: Assign a distinguishing claim file identification number to each claim report. This number must be sufficient identification to enable tracking of a particular claim.
2b. **Date of Injury**: Date principal or alleged injury occurred.
2c. **Date Reported**: Date when claim was first reported to insurer or self-insurer.
2d. **Date Reopened**: Date claim was reopened.
2e. **Original Claim Number** (If Claim is Reopened): If claim is reopened, original claim number used when claim was originally filed with the Department.
2f. **Place of Occurrence Code**: Enter the appropriate code for the place where the principal injury occurred:
(1) Hospital Inpatient Facility
(2) Emergency Room
(3) Hospital Outpatient Facility
(4) Nursing Home
(5) Physician's Office
(6) Patient's Home
(7) Other Outpatient Facility (including clinics)
(8) Other (describe place)
If the claim resulted from a diagnostic error, code place where error occurred, regardless of where it was discovered or treated.
2g. **Place of Occurrence Address**: Enter the address where the injury occurred.
2h. **Total Number of Defendants in Claim** Enter total number of defendants (persons and institutions other than John Does) involved in claim.
2i. **Companion Claim File Identification** Enter claim file identification numbers for all claims against other defendants involved in this same incident.
3a. **Insured's Name**: Enter name of insured
3b. **License Number**: Enter New Hampshire license number of insured health care professional. If unavailable, enter federal identification number; not applicable to clinics and corporations.
3c. **Date of Birth**: Enter insured's date of birth. Enter 'N/A' if an institution, group or partnership.
3d. **Address**: Enter complete address of insured.
3e. **Profession Code of Insured** Enter appropriate code for insured named in 3a.
(01) Physician and/or Surgeon
(02) Hospital
(03) Nurse
(04) Nursing Home
(05) Dentist
(06) Pharmacy
(07) Optometrist
(08) Chiropractor
(09) Podiatrist / Chiropodist
(99) Clinic / Corporation / Other
3f. **Specialty Code of Insured** Enter appropriate 5-digit specialty code. Licensed insurers - use ISO Common Statistical Base Classification Code used for underwriting. Self-insurers - contact Insurance Department for list of codes.
3g. **Practice Code of Insured**: Enter one of the following codes if the insured is a physician or other medical professional. Not applicable if hospital or health care facility is the insured.
(01) Institutional (including academic)
(02) Professional Corporation or Partnership (Group)
(03) Self-employed
(04) Employed Physician
(05) Employed Nurse
(06) Intern or Resident
(99) All Other Employees
4a. **Name of Institution**: Enter name of institution, if injury occurred in an institution (2f. should be coded 1, 2, 3, 4, 7, or 8). Otherwise enter 'N/A'.
4b. **Address of Institution** Enter address of institution, if injury occurred in an institution.
4c. **Location of Injury Code** Enter appropriate code for location within institution where injury occurred:
(1) Patient's Room
(2) Labor and Delivery Room
(3) Operating Room
(4) Recovery
(5) Critical Care Unit
(6) Special Procedure Room
(7) Nursery
(8) Radiology
(9) Physical Therapy Department
Applicable only when 2f. is coded 1 or 4, otherwise enter 'N/A'.
5a. **Name of Injured Person**: Enter name of injured person.
5b. **Date of Birth**: Enter injured person's date of birth..
5c. **Sex**: Enter sex of injured person as 'M' (male) or 'F' (female).
5d. **Address**: Enter complete address of injured person.
6a. **Name of Person Instituting the Claim**(if Injured Person is Deceased or a Minor): Enter name.
6b. **Address**: Enter address of person from 6a..
7a. **Plaintiff Attorney's Name**: Enter name of attorney.
7b. **Plaintiff Attorney's Firm**: Enter firm of attorney.
7c. **Plaintiff Attorney's Address** Enter address of attorney.
8a. **Nature and Substance of Claim** Give a complete description of all actions and circumstances causing the claim. Include allegations made by claimant. Provide information on other healthcare professionals involved in the claim or having alleged liability for the injury.
8b. **Severity of Injury Code**: Enter severity of injury from scale provided below. Code principal injury if several injuries are involved:

	Severity of Injury Scale	Examples
Temporary	(01) Emotional Only	Fright, no physical damage
	(02) Insignificant	Lacerations, contusions, minor scars, rash. No delay.
Temporary	(03) Minor	Infections, mis-set fracture, fall in hospital. Recovery delayed.
Temporary	(04) Major	Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
Permanent	(05) Minor	Loss of Fingers, loss or damage to organs. Includes nondisabling injuries.
Permanent	(06) Significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung.
Permanent	(07) Major	Paraplegia, blindness, loss of two limbs, brain damage.
Permanent	(08) Grave	Quadriplegia, sever brain damage, life long care or fatal prognosis.
Permanent	(09) Death	

8c. **Act or Omission Codes** Identify the relationship to claim: Diagnosis, Anesthesia, Surgery, Medication, Intravenous and Blood Products, Obstetrics, Treatment, Monitoring, Biomedical Equipment/Product, Miscellaneous. Enter the appropriate three-digit omission code. List of omission codes available from the New Hampshire Insurance Department.
9a. **Reserve Amount for Indemnity** Enter amount.
9b **Reserve Amount for Expense** Enter amount.
10. **Date of Payment or Closure**: Enter date. For a reopened case, enter new closure date.
11. **Screening Panel Code**: Enter code reflecting screening panel status or outcome:
(01) Screening panel proceedings not yet initiated
(02) Panel proceedings in progress - Presentations to panel not yet held
(03) Panel proceedings in progress - Presentations to panel held; panel findings not yet released
(04) Panel findings released - RSA 519-B:6, both I(a) and (b) unanimous and unfavorable to defendant
(05) Panel findings released - RSA 519-B:6, any of I(a), (b) or (c) unanimous and unfavorable to plaintiff
12. **Settlement Code**: Enter the appropriate code reflected when the settlement occurred:
(01) Before filing suit or demanding arbitration.
(02) Before initiation of screening panel proceedings
(03) After initiation of panel proceedings and prior to release of panel findings
(04) After release of panel findings and prior to initiation of court proceedings
(05) During trial.
(06) After trial, but before judgment or decision (award).
(07) After judgment or decision, but before appeal.
(08) During appeal.
(09) After appeal.
(10) Claim or suit abandoned by plaintiff.
13a. **Court Code**: For all claims, enter the appropriate court code.
(00) No Court proceedings were initiated.
(01) Directed verdict for plaintiff.
(02) Directed verdict for defendant.
(03) Judgment notwithstanding, verdict for plaintiff.
(04) Judgment notwithstanding, verdict for defendant.
(05) Judgment for plaintiff.
(06) Judgment for defendant.
(07) Judgment for plaintiff after appeal.
(08) Judgment for defendant after appeal.
(99) All other (including dismissals and claims settled after initiation of proceedings).
13b. **Name of Court**: Enter court in which suit was filed.
13c. **Docket Number**: Enter the docket number assigned by the court.
13d. **Date Suit was Filed**: Enter the filing date if a suit has been filed.
14. **Indemnity paid by you on behalf of this defendant** Enter indemnity paid you on behalf of this defendant. If more than one policy is involved, total the amounts paid by you under all policies.
14a. **Economic damages**: Enter from item 14, the amount of damages arising from pecuniary harm including, without limitation, medical damages and those damages arising from lost wages and lost earning capacity.
14b. **Non-economic damages**: Enter from item 14, the amount of damages arising from nonpecuniary harm including, without limitation, pain, suffering, mental anguish, inconvenience, physical impairment, disfigurement, loss of capacity to enjoy life and loss of consortium, but shall not include punitive damages.
14c. **Punitive damages**: Enter from item 14, the amount of punitive damages intended to punish or deter willful, wanton or malicious misconduct.
15. **Other indemnity paid by or on behalf of this defendant** Enter all indemnity paid by other parties on behalf of this defendant.
16. **Indemnity paid by all parties (for all defendants)** Enter all indemnity paid by all parties on behalf of all defendants involved in this claim.
17. **Loss adjustment expense paid to defense counsel** Enter loss adjustment expense paid by you to defense counsel for this defendant.
18. **All other allocated adjustment expense paid by you** Enter all allocated loss adjustment expense paid by you for this defendant. Include filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc.

For items 19 through 23, actual amounts should be reported. If unknown, report estimated amounts. If estimated amounts are reported, please indicate by including. '(est.)' after $$$ amount entered.
19. **Injured person's incurred medical expense** Enter amount of insured medical expense form date of injury to date of closure.
20. **Injured person's anticipated future medical expense** Enter total future medical expense if it appears the claimant will incur expenses in the future.
21. **Injured person's incurred wage loss** Enter amount of wage loss from date of injury to date of closure.
22. **Injured person's anticipated future wage loss** Enter total future wage loss if it appears the claimant will incur wage loss in the future.
23. **Injured person's other expenses** Enter amount of incurred plus future expense for substitute services and all other expense. Include funeral expense here.

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Name Title Tel. No. E-Mail

CLAIM FILE IDENTIFICATION

2a Claim Number	2b Date of Injury	2c Date Reported	2d Date Reopened	2e Original Claim Number

2f Place of Occurrence Code	2g Place of Occurrence Address	2h Total Number of Defendants in Claim

2i Companion Claim File Identification

1 **2** **3** **4**

INSURED

3a Name	3b License Number	3c Date of Birth

3d Address (Street, P.O. Box, City/Town, State, Zip Code)

3e Profession Code of Insured	3f Specialty Code of Insured	3g Practice Code of Insured

INSTITUTION (IF INJURY OCCURRED IN INSTITUTION)

4a Name:	4b Address:	4c Location of Injury Code:

INJURED PERSON

5a Name	5b Date of Birth	5c Sex
5d Address		

6a Name of Person Instituting the Claim, if injured person is deceased or a minor

6b Address

7a Plaintiff Attorney's Name	7b Plaintiff Attorney's Firm	7c Address

CLAIM INFORMATION AND SETTLEMENT DATA

8a Nature and Substance of Claim	8b Severity of Injury Code

8c Act or Omission Codes (Enter three Digit Code in Appropriate Category)

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1a. **Name of Insurer**: Enter name of company or self-insurer reporting this claim.
1b. **Address of Insurer**: Enter address of company or self-insurer reporting this claim
1c. **NAIC Group & Company Code** For insurance companies use NAIC group-company code; self-insurers contact Insurance Department for assigned number.
1d. **Contact Person Responsible for the Report.** Enter contact's name, title, tel. #, e-mail address.
2a. **Claim Number**: Assign a distinguishing claim file identification number to each claim report. This number must be sufficient identification to enable tracking of a particular claim.
2b. **Date of Injury**: Date principal or alleged injury occurred.
2c. **Date Reported**: Date when claim was first reported to insurer or self-insurer.
2d. **Date Reopened**: Date claim was reopened.
2e. **Original Claim Number** (If Claim is Reopened): If claim is reopened, original claim number used when claim was originally filed with the Department.
2f. **Place of Occurrence Code**: Enter the appropriate code for the place where the principal injury occurred:
(1) Hospital Inpatient Facility
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(5) Physician's Office
(6) Patient's Home
(7) Other Outpatient Facility (including clinics)
(8) Other (describe place)
If the claim resulted from a diagnostic error, code place where error occurred, regardless of where it was discovered or treated.
2g. **Place of Occurrence Address**: Enter the address where the injury occurred.
2h. **Total Number of Defendants in Claim** Enter total number of defendants (persons and institutions other than John Does) involved in claim.
2i. **Companion Claim File Identification** Enter claim file identification numbers for all claims against other defendants involved in this same incident.
3a. **Insured's Name**: Enter name of insured
3b. **License Number**: Enter New Hampshire license number of insured health care professional. If unavailable, enter federal identification number; not applicable to clinics and corporations.
3c. **Date of Birth**: Enter insured's date of birth. Enter 'N/A' if an institution, group or partnership.
3d. **Address**: Enter complete address of insured.
3e. **Profession Code of Insured** Enter appropriate code for insured named in 3a.
(01) Physician and/or Surgeon
(02) Hospital
(03) Nurse
(04) Nursing Home
(05) Dentist
(06) Pharmacy
(07) Optometrist
(08) Chiropractor
(09) Podiatrist / Chiropodist
(99) Clinic / Corporation / Other
3f. **Specialty Code of Insured** Enter appropriate 5-digit specialty code. Licensed insurers - use ISO Common Statistical Base Classification Code used for underwriting. Self-insurers - contact Insurance Department for list of codes.
3g. **Practice Code of Insured** Enter one of the following codes if the insured is a physician or other medical professional. Not applicable if hospital or health care facility is the insured.
(01) Institutional (including academic)
(02) Professional Corporation or Partnership (Group)
(03) Self-employed
(04) Employed Physician
(05) Employed Nurse
(06) Intern or Resident
(99) All Other Employees
4a. **Name of Institution**: Enter name of institution, if injury occurred in an institution (2f. should be coded 1, 2, 3, 4, 7, or 8). Otherwise enter 'N/A'.
4b. **Address of Institution** Enter address of institution, if injury occurred in an institution.
4c. **Location of Injury Code** Enter appropriate code for location within institution where injury occurred:
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(8) Radiology
(9) Physical Therapy Department
Applicable only when 2f. is coded 1 or 4, otherwise enter 'N/A'.
5a. **Name of Injured Person**: Enter name of injured person.
5b. **Date of Birth**: Enter injured person's date of birth..
5c. **Sex**: Enter sex of injured person as 'M' (male) or 'F' (female).
5d. **Address**: Enter complete address of injured person.
6a. **Name of Person Instituting the Claim**(if Injured Person is Deceased or a Minor): Enter name.
6b. **Address**: Enter address of person from 6a..
7a. **Plaintiff Attorney's Name**: Enter name of attorney.
7b. **Plaintiff Attorney's Firm**: Enter firm of attorney.
7c. **Plaintiff Attorney's Address** Enter address of attorney.
8a. **Nature and Substance of Claim** Give a complete description of all actions and circumstances causing the claim. Include allegations made by claimant. Provide information on other healthcare professionals involved in the claim or having alleged liability for the injury.
8b. **Severity of Injury Code**: Enter severity of injury from scale provided below. Code principal injury if several injuries are involved:

	Severity of Injury Scale	Examples
Temporary	(01) Emotional Only	Fright, no physical damage
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Permanent	(05) Minor	Loss of Fingers, loss or damage to organs. Includes nondisabling injuries.
Permanent	(06) Significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung.
Permanent	(07) Major	Paraplegia, blindness, loss of two limbs, brain damage.
Permanent	(08) Grave	Quadriplegia, sever brain damage, life long care or fatal prognosis.
Permanent	(09) Death	

8c. **Act or Omission Codes** Identify the relationship to claim: Diagnosis, Anesthesia, Surgery, Medication, Intravenous and Blood Products, Obstetrics, Treatment, Monitoring, Biomedical Equipment/Product, Miscellaneous. Enter the appropriate three-digit omission code. List of omission codes available from the New Hampshire Insurance Department.
9a. **Reserve Amount for Indemnity** Enter amount.
9b **Reserve Amount for Expense** Enter amount.
10. **Date of Payment or Closure**: Enter date. For a reopened case, enter new closure date.
11. **Screening Panel Code**: Enter code reflecting screening panel status or outcome:
(01) Screening panel proceedings not yet initiated
(02) Panel proceedings in progress - Presentations to panel not yet held
(03) Panel proceedings in progress - Presentations to panel held; panel findings not yet released
(04) Panel findings released - RSA 519-B:6, both I(a) and (b) unanimous and unfavorable to defendant
(05) Panel findings released - RSA 519-B:6, any of I(a), (b) or (c) unanimous and unfavorable to plaintiff
12. **Settlement Code**: Enter the appropriate code reflected when the settlement occurred:
(01) Before filing suit or demanding arbitration.
(02) Before initiation of screening panel proceedings
(03) After initiation of panel proceedings and prior to release of panel findings
(04) After release of panel findings and prior to initiation of court proceedings
(05) During trial.
(06) After trial, but before judgment or decision (award).
(07) After judgment or decision, but before appeal.
(08) During appeal.
(09) After appeal.
(10) Claim or suit abandoned by plaintiff.
13a. **Court Code**: For all claims, enter the appropriate court code.
(00) No Court proceedings were initiated.
(01) Directed verdict for plaintiff.
(02) Directed verdict for defendant.
(03) Judgment notwithstanding, verdict for plaintiff.
(04) Judgment notwithstanding, verdict for defendant.
(05) Judgment for plaintiff.
(06) Judgment for defendant.
(07) Judgment for plaintiff after appeal.
(08) Judgment for defendant after appeal.
(99) All other (including dismissals and claims settled after initiation of proceedings).
13b. **Name of Court**: Enter court in which suit was filed.
13c. **Docket Number**: Enter the docket number assigned by the court.
13d. **Date Suit was Filed**: Enter the filing date if a suit has been filed.
14. **Indemnity paid by you on behalf of this defendant** Enter indemnity paid you on behalf of this defendant. If more than one policy is involved, total the amounts paid by you under all policies.
14a. **Economic damages**: Enter from item 14, the amount of damages arising from pecuniary harm including, without limitation, medical damages and those damages arising from lost wages and lost earning capacity.
14b. **Non-economic damages**: Enter from item 14, the amount of damages arising from nonpecuniary harm including, without limitation, pain, suffering, mental anguish, inconvenience, physical impairment, disfigurement, loss of capacity to enjoy life and loss of consortium, but shall not include punitive damages.
14c. **Punitive damages**: Enter from item 14, the amount of punitive damages intended to punish or deter willful, wanton or malicious misconduct.
15. **Other indemnity paid by or on behalf of this defendant** Enter all indemnity paid by other parties on behalf of this defendant.
16. **Indemnity paid by all parties (for all defendants)** Enter all indemnity paid by all parties on behalf of all defendants involved in this claim.
17. **Loss adjustment expense paid to defense counsel** Enter loss adjustment expense paid by you to defense counsel for this defendant.
18. **All other allocated adjustment expense paid by you** Enter all allocated loss adjustment expense paid by you for this defendant. Include filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc.

For items 19 through 23, actual amounts should be reported. If unknown, report estimated amounts. If estimated amounts are reported, please indicate by including. '(est.)' after $$$ amount entered.

19. **Injured person's incurred medical expense** Enter amount of insured medical expense form date of injury to date of closure.
20. **Injured person's anticipated future medical expense** Enter total future medical expense if it appears the claimant will incur expenses in the future.
21. **Injured person's incurred wage loss** Enter amount of wage loss from date of injury to date of closure.
22. **Injured person's anticipated future wage loss** Enter total future wage loss if it appears the claimant will incur wage loss in the future.
23. **Injured person's other expenses** Enter amount of incurred plus future expense for substitute services and all other expense. Include funeral expense here.